

LEB AUG 28 1941

Registration District No. 89

Primary Registration District No.

573-5134B

Registrar's No.

323

1. PLACE OF DEATH:

(a) County Butler County  
(b) City or town Butler, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ash Hill Trpo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)  
In this community \_\_\_\_\_

3. (a) PRINT FULL NAME SALLIE NORED

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race W 6. (a) Single widowed, married, divorced  
6. (b) Name of husband or wife T. T. Nored 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased Dec. 25 1875 (Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Stone County, Arkansas (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name G. W. Callow  
13. Birthplace Yenn (City, town, or county) (State or foreign country)  
14. Maiden name Hancock  
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant T. T. Nored  
(b) Address Butler, Mo. R. 1  
17. (a) Burial (b) Date thereof 8-17-41 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Butler Cemetery

18. (a) Signature of funeral director Landes Funeral Home  
(b) Address Campbell, Mo.

19. (a) 8-19-41 (b) Belle Kinne (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler  
(c) City or town Butler, Mo. R. 1 (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16 year 1941 hour \_\_\_\_\_ minute 1:35 AM

21. I hereby certify that I attended the deceased from June 30 1941 to Aug 16 1941  
that I last saw him alive on June 30 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 76 hrs

Due to \_\_\_\_\_

Due to 83A

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature W. J. Ruedger (M. D. or other) MD  
Address Campbell, Mo Date signed 8/16/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office

District File Number 841-

Date Filed 8-26-

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Christina M. Landers

Licensed Embalmer No. 4227

P. O. Address Campbell, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27916  
Registrar's No. 323

Registration District No. 89

Primary Registration District No. 5131

1. PLACE OF DEATH:

- (a) County Butler  
(b) City or town Oulin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT  
FULL NAME

Salie Hored

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security  
No. \_\_\_\_\_

4. Sex F

5. Color or  
race W

6. (a) Single, widowed, married,  
divorced Married

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 10-8-41

(Date received local registrar)

(b) Butler Hored

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1  
year 1941 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_;  
that I saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

